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No. 06-923

IN THE

Supreme Court of the United States

METROPOLITAN LIFE INSURANCE COMPANY AND LONG TERM DISABILITY PLAN FOR ASSOCIATES OF SEARS, ROEBUCK AND COMPANY,

Petitioners,

v.

WANDA GLENN,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Sixth Circuit

REPLY BRIEF FOR PETITIONERS

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RULE 29.6 STATEMENT

The corporate disclosure statement included in the petition for a writ of certiorari remains accurate.

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REPLY BRIEF FOR PETITIONERS

Respondent advances three principal positions in her brief: that entities that both evaluate and pay claims for an ERISA disability plan *always* operate under a conflict of interest that must be weighed on judicial review; that benefit determinations by such entities should be subject to exacting judicial scrutiny, up to and including *de novo* review; and that MetLife abused its discretion in terminating respondent's disability benefits. Respondent's arguments, like those of the United States, depart radically from this Court's existing interpretations of ERISA, from the policy objectives that animate the statute, and from the trust-law and contract principles that this Court applies when interpreting ERISA.

Respondent and the United States first contend that companies that act as fiduciaries and that separately fund claims, *without more*, operate under a conflict of interest that must be weighed on judicial review, even where the plan documents anticipate such a conflict and grant full discretion to the fiduciary. Their argument has far-reaching implications for employee benefit plans because claims under the vast majority of such plans are administered either by the employer itself or by an insurance company that funds plan benefits. Thus, under the reasoning of respondent and the United States, almost *every* discretionary benefit determination would be reviewed under a standard more rigorous than the pure abuse-of-discretion standard that plan sponsors have a contractual right to designate by delegating discretionary authority under the terms of their plans. *See Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989). This heightened scrutiny of discretionary benefit determinations would signifi-

cantly impair the contractual freedom preserved by ERISA. It would also inevitably encourage litigation by plan participants with dubious claims and—in direct contravention of ERISA's statutory objectives—dissipate plan funds that could otherwise be used to stabilize the cost of coverage or offer more generous benefits to plan participants.

Respondent and the United States further argue that, in cases where a fiduciary also funds the benefits, without more, courts should "carefu[lly] scrutin[ize]" the fiduciary's decision by "re-weigh[ing]" all of the evidence before the fiduciary under the criteria set forth in a seven-pronged test similar to the one articulated by *Abatie v. Alta Health & Life Insurance Co.*, 458 F.3d 955 (9th Cir. 2006) (en banc). Resp. Br. 44; *see also* U.S. Br. 27. This reformulation of the standard for reviewing discretionary benefit determinations of fiduciaries operating under a conflict of interest is flatly inconsistent with *Firestone*, which provides that a conflict of interest "must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" 489 U.S. at 115 (quoting Restatement (Second) of Trusts § 187 cmt. d (1959)) (alteration in original). The multi-pronged test proposed by respondent and the United States is also flawed from a practical standpoint because (1) it fails to provide meaningful guidance to courts, which would be left to speculate about the scope and relative weight of each factor; (2) it would likely cause courts to become preoccupied with the conflict issue and to give diminished attention to whether the actual decision was reasonable under the terms of the plan; and (3) it thwarts the goals of ERISA by encouraging class-action type discovery.

Finally, respondent's and the United States' application of their proposed standard of review to the

facts of this case mischaracterizes the administrative record and vividly highlights the flaws in their proposed multi-factor test. Indeed, they do not dispute that MetLife's conclusion that respondent did not meet the Plan's post-24-month definition of "Total Disability" was based on the fact that the opinion of her treating physician was contradicted by her medical and vocational records and four other medical opinions—including her own physician's pre-termination opinions. If MetLife's resolution of this evidentiary conflict can be second-guessed by a court, then there is virtually no benefit determination that could not be overturned on judicial review.

I. METLIFE WAS NOT OPERATING UNDER A CONFLICT OF INTEREST THAT MUST BE WEIGHED ON JUDICIAL REVIEW WHEN IT TERMINATED RESPONDENT'S BENEFITS.

ERISA's text, structure, and purpose establish that entities that both evaluate and pay benefit claims do not, without more, operate under a conflict of interest that must be weighed on judicial review. In an effort to circumvent the clear implications of these interpretive guideposts, respondent and the United States marginalize ERISA's statutory text, invoke irrelevant trust-law principles that post-date ERISA's enactment, and adopt a restrictive view of ERISA's statutory objectives. None of these arguments can conceal the flaws in the court of appeals' conclusion that MetLife was operating under a conflict of interest of such weight when it terminated respondent's benefits that its reliance on persuasive medical and vocational information was wrong.[1]

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[1] As an initial matter, respondent observes that "[m]ost circuits disagree with MetLife's position" in this case. Resp. Br.

A. Respondent's Arguments Conflict With The Language, Structure, And Purpose Of ERISA.

1. In contending that entities that both evaluate and pay claims always operate under a conflict of interest that must be weighed on judicial review, respondent and the United States disregard the most relevant textual provisions of ERISA. For example, although respondent acknowledges that ERISA explicitly "authorizes" an employer—or any agent of the employer—responsible for funding a benefit plan to serve in a fiduciary capacity as claim administrator, she contends that this provision does not "say anything" about whether such a company is operating under a conflict of interest that must be weighed on judicial review. Resp. Br. 20 (citing 29 U.S.C. § 1108(c)(3)) (emphasis omitted). If Congress believed, however, that all entities that both evaluate and pay benefit claims are operating under a conflict of interest that is potentially detrimental to plan participants and that requires heightened judicial review, it is inconceivable that it would have provided express authorization for this arrangement.

Respondent and the United States nevertheless proceed as if ERISA were silent on this issue and se-

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[Footnote continued from previous page]

12. *Firestone* itself makes clear, however, that this Court has never hesitated to endorse interpretations of ERISA previously rejected by a majority of circuits. 489 U.S. at 109, *see also Buckhannon Bd. & Care Home, Inc. v. W. Va. Dep't of Health & Human Res.*, 532 U.S. 598, 621 (2001) (Scalia, J., concurring) ("[O]ur disagreeing with a 'clear majority' of the Circuits is not at all a rare phenomenon. Indeed, our opinions sometimes contradict the *unanimous* and long-standing interpretation of lower federal courts.").

lectively highlight other aspects of the statutory scheme. The United States, for example, emphasizes that "Congress imposed strict standards of loyalty and care" when it enacted ERISA and that it "intended in particular to prevent trustees from engaging in actions where there would be a conflict of interest." U.S. Br. 17 (internal quotation marks omitted). But these observations ignore the explicit *exception* to these background principles created by 29 U.S.C. § 1108(c)(3). The United States also disregards the fact that ERISA gives such wide discretion to employers in structuring their plans—to which the duty of loyalty and care runs—that it expressly authorizes a fiduciary to have "financial interests adverse to beneficiaries" as long as the fiduciary does not act upon those interests when making fiduciary decisions. *Pegram v. Herdrich*, 530 U.S. 211, 225 (2000).

Requiring courts to weigh on judicial review as a purported "conflict" the bare fact that a fiduciary is responsible for paying claims, without evidence that the fiduciary's decision was infected by self-dealing, is also inconsistent with the fact that "[n]either general principles of trust law nor a concern for impartial decisionmaking . . . forecloses parties from agreeing upon a narrower standard of review" than the default *de novo* standard. *Firestone*, 489 U.S. at 115; *see also* Br. for the United States as Amicus Curiae at 13, *Black & Decker Disability Plan v. Nord*, 538 U.S. 822 (2003) (No. 02-469) ("employers are free under ERISA to design plans that grant discretion to the plan administrator to interpret plan terms and make eligibility determinations"). In accordance with this principle, the Court has stated that, where a "benefit plan gives the . . . fiduciary discretionary authority to determine eligibility for benefits," the

fiduciary's decision will be reviewed for an abuse of discretion. *Firestone*, 489 U.S. at 115.[2]

Respondent and the United States, however, would effectively rewrite ERISA to provide that employers may not elect a pure abuse-of-discretion standard of review for benefit determinations if the entity deciding claims is also the source of funding. If this Court adopted the position advocated by respondent and the United States, benefit determinations would *rarely* be subject to the pure abuse-of-discretion standard of review because, under the vast majority of plans, claims are administered either by insurance companies or by employers responsible for providing the funding.

Indeed, under the position of respondent and the United States that any potential financial interest in a transaction—no matter how attenuated—gives rise to a conflict of interest that must be weighed on judicial review, even an independent third party hired by a plan sponsor to make benefit determinations could be allegedly operating under such a conflict because the claim administrator would theoretically have an incentive to deny borderline claims in order to minimize the plan sponsor's costs and augment its chances of being rehired. The concern about the breadth of these conflict arguments is far from theoretical, as similar challenges to the impartiality of third-party claim administrators have been raised in the past. *See, e.g.*, *Weidner v. Fed. Express Corp.*, 492 F.3d 925, 930 (8th Cir. 2007). Thus, if the decision below were affirmed, there could be virtually no

[2] For this reason, it is irrelevant that, prior to the enactment of ERISA, an employee's breach-of-contract action alleging that the insurer had wrongfully withheld benefits would have resulted in *de novo* review of the claim. Resp. Br. 14.

situation in which courts would apply the abuse-of-discretion standard. The Court should reject this backdoor effort to overrule *Firestone*'s holding that employers may decide to alter the default *de novo* standard of review under the terms of the plan.[3]

2. Respondent and the United States also misconstrue the trust-law principles that served as the backdrop for ERISA's enactment and that inform its interpretation.

As an initial matter, both respondent and the United States rely heavily on the Restatement (Third) of Trusts to support their position that every potential conflict of interest must be weighed on judicial review of a claim determination, even if there is no indication that the fiduciary's decision-making was infected by that conflict. *See, e.g.*, Resp. Br. 24, 25, 42; U.S. Br. 14, 24, 25. But the Restatement (Third) sheds little, if any, light on Congress's intentions when enacting ERISA because it was published

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[3] Respondent misreads *Firestone* when she suggests that the threshold conflict-of-interest issue in this case is controlled by the Court's statement that, where a "fiduciary . . . is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" 489 U.S. at 115 (quoting Restatement (Second) of Trusts § 187 cmt. d) (alteration in original). Although that statement certainly provides guidance regarding the standard to be employed in reviewing a benefit determination by a fiduciary who was *actually influenced* by self-interest, it does not answer the question whether a fiduciary that both evaluates and pays claims is *always* "operating under" a conflict of interest that must be weighed on judicial review. The Court's statement merely reflects the trust-law principle that a conflict must be weighed as a factor where it is shown that the trustee is "operating under"—i.e., influenced by—its own self-interest. *See also infra* note 4.

more than a quarter century *after* ERISA was enacted. *See Director v. Greenwich Collieries*, 512 U.S. 267, 275 (1994) ("We . . . presume Congress intended [a] . . . phrase to have the meaning generally accepted in the legal community at the time of enactment."). Indeed, this Court has never cited it when interpreting ERISA and has instead relied upon the Restatement (Second) of Trusts to illuminate Congress's intentions when enacting ERISA. *See, e.g., LaRue v. DeWolff, Boberg & Assocs.*, 128 S. Ct. 1020, 1024 n.4 (2008).

The Restatement (Second) makes clear that, where a potential conflict of interest is contemplated by the trust documents, that conflict is taken into account *only* when there is evidence suggesting that the trustee's decision-making was infected by that conflict. The Restatement (Second) explains, for example, that "[a]lthough ordinarily the court will not inquire into the motives of the trustee, yet if it is shown that his motives were improper or that he could not have acted from a proper motive, the court will interpose." Restatement (Second) of Trusts, § 187 cmt. g. The Restatement (Second) provides the following illustration:

> A devises Blackacre to B in trust and directs B to sell Blackacre if in his judgment such sale would be for the best interest of the beneficiaries. It clearly appears that a sale would be highly advantageous to the beneficiaries, but B refuses to sell the land solely on the ground that the purchaser would probably use the land in a manner to cause a depreciation in value of B's own land situated nearby. The court may order a sale of land.

Id. § 187 cmt. g, illus. 2.

Under the Restatement (Second), then, courts may overturn the decision of a trustee with a potential conflict of interest only when it is "shown" that the trustee acted under the influence of that interest when making a decision. Courts do not take account of a *potential* conflict of interest where there is no indication that the trustee actually acted on the basis of that interest. *See, e.g., In re Pincus' Estate*, 105 A.2d 82, 86 (Pa. 1954) (where a conflict of interest was contemplated in the trust, a trustee's discretionary decision cannot be overturned unless "bad faith on the part of the fiduciary [is] affirmatively shown"); *Gregory v. Moose*, 590 S.W.2d 665, 670 (Ark. Ct. App. 1979) (refusing to invalidate a transaction from which a trustee benefited personally because the transaction was contemplated by the settlor and was not "dishonest, or fraudulent, or intentionally detrimental to one or more beneficiaries").[4]

Applied in the ERISA setting, this trust-law principle establishes that, where a fiduciary has an interest that is potentially adverse to that of a plan participant, the fiduciary's decision can only be overturned on the basis of that potential conflict where the plaintiff "show[s]" that the fiduciary acted im-

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[4] Comment d to Section 187 of the Restatement (Second), invoked by respondent (at 24-25), is not to the contrary. It merely provides that the "existence or nonexistence of an interest in the trustee conflicting with that of the beneficiaries" "*may* be relevant" to determining whether the trustee abused its discretion. As comment g to Section 187, and its illustrations, make clear, the existence of such an interest is *not* relevant on judicial review where the potential conflict is contemplated in the trust documents and there is no evidence that the trustee's decision was infected by self-dealing.

properly to further its own interests. Absent such a showing, however, the potential conflict of interest may not be weighed on judicial review of a benefit determination by the fiduciary. *See also infra* Section I.A.3 (duty of loyalty is due to the plan itself and *all* participants and beneficiaries).

Moreover, even if trust law did support the position of respondent and the United States, trust law is merely a "guide[ ]" for construing ERISA. *Firestone*, 489 U.S. at 111. This Court does not invariably adhere to trust law's guidance where other indicia of statutory meaning—such as the text and purpose—yield a different result. *See Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 219 (2002) (deeming trust-law principles to be "inapposite" because the relief sought was foreclosed by ERISA's plain language); *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 259 (1993) ("The authority of courts to develop a 'federal common law' under ERISA is not the authority to revise the text of the statute."). Here, the statutory text of ERISA unambiguously establishes that Congress did not consider entities that both evaluate and pay claims, without more, to be operating under a conflict of interest and did not intend to restrict employers' freedom to design a plan subject to a standard of review different than ERISA's default standard. To the extent there is any inconsistency between trust law and these statutory principles, the conflict would have to be resolved in favor of ERISA's text.

3. Respondent and the United States are equally unsuccessful in their effort to reconcile the Sixth Circuit's holding with ERISA's dual policies of encouraging the formation of employee benefit plans and protecting the interests of all plan participants.

Respondent and the United States essentially contend that any procedural rule that increases the likelihood that an individual plan participant will receive benefits is consistent with ERISA's objectives. But this simplistic characterization of ERISA's goals overlooks the fact that "a fiduciary obligation, enforceable by beneficiaries seeking relief for themselves, does not necessarily favor payment over nonpayment." *Varity Corp. v. Howe*, 516 U.S. 489, 514 (1996). "The common law of trusts," the Court has explained, "recognizes the need to preserve assets to satisfy future, as well as present, claims and requires a trustee to take impartial account of the interests of all beneficiaries." *Id.* (citing Restatement (Second) Trusts §§ 183, 232). The fiduciary obligations of ERISA claim administrators therefore run not only to individual plan participants but also to the plan as a whole. The fiduciary duties that bind claim administrators thus strongly favor the denial of nonmeritorious claims and the preservation of plan funds for the payment of claims filed by participants who satisfy the plan's benefit requirements. *See Gaither v. Aetna Life Ins. Co.*, 394 F.3d 792, 807 (10th Cir. 2004) ("a fiduciary has a duty to protect the plan's assets against spurious claims").[5]

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[5] Indeed, the Plan's post-24-month definition of "Total Disability" is very restrictive—requiring the claimant to demonstrate that she is "totally incapable of performing the material duties of any gainful occupation for which [she is] reasonably qualified" (J.A. 160a)—in part due to the ethical hazard created by the availability of disability benefits. To ensure that the cost of sponsoring the plan does not become prohibitively expensive for the employer or other participants, an administrator in MetLife's position must carefully scrutinize benefit claims for compliance with the definitions set forth in the plan.

Accordingly, ERISA's procedural framework is not designed simply to maximize the chances that judicial review will culminate in a decision that a participant is entitled to benefits. Courts are required to review a benefit determination in a manner that distinguishes between meritorious and nonmeritorious claims and that therefore furthers ERISA's objective of minimizing the "administrative and financial burdens on plan administrators." *Egelhoff v. Egelhoff*, 532 U.S. 141, 150 (2001) (internal quotation marks omitted). Recasting and diluting the pure abuse-of-discretion standard of review specified in the plan documents based on the mere fact that an entity both evaluates and pays claims, without any indication that the benefit determination was infected by self-interest, increases the likelihood that participants with questionable claims will file suit. That in turn increases the likelihood that the plan will be compelled to pay additional litigation costs (and, if the suit is successful, unwarranted benefits) with funds that could otherwise have been used to stabilize premiums or to allow enhanced coverage to other plan participants.

Respondent's contention that there is no empirical evidence that a heightened standard of review for claim denials fosters litigation disregards the realities of ERISA litigation. Federal courts are asked to resolve nearly ten thousand ERISA claims every year. Administrative Office of the United States Courts, *Judicial Business of the United States Courts* tbl. c-2 (2008). Because the majority of circuits are now applying the conflict-of-interest rule that respondent urges—holding that entities that both evaluate and pay claims always operate under a conflict of interest that must be weighed on judicial review—it is reasonable to conclude that the large vol-

ume of ERISA litigation is attributable at least in part to the heightened standard of review. It stands to reason that disappointed claimants are more likely to file suit where a court will closely scrutinize the claim administrator's decision under an open-ended and malleable multi-factor test than where the court will apply a more deferential and predictable abuse-of-discretion standard of review. Indeed, in the four years after this Court's holding in *Firestone* that the default standard under ERISA is *de novo* review (rather than the arbitrary-and-capricious standard that had been adopted by most circuits), the volume of ERISA litigation increased by seventeen percent, which leaves little doubt about the connection between heightened judicial review of benefit determinations and increases in litigation volume. *Compare* Administrative Office of the United States Courts, *Judicial Business of the United States Courts* tbl. c-2 (1995) (1994 caseload figures), *with* Administrative Office of the United States Courts, *Judicial Business of the United States Courts* tbl. c-2 (1991) (1990 caseload figures).

4. In sum, neither respondent nor the United States has provided any basis for overriding the provision of the present benefit plan calling for pure abuse-of-discretion review of MetLife's benefit determinations. That provision states unequivocally that MetLife "shall have the *discretionary* authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits" and that "*[a]ny* interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was *arbitrary and capricious*." J.A. 181a-82a (emphases added). Respondent and the United States believe

ERISA necessarily overrides that provision and requires the application of a *modified* abuse-of-discretion standard in which a judicial thumb—of at least some weight—is placed on the scale. There is simply no warrant, however, in ERISA, its history, or the policies that underlie the statute for such an automatic modification of the pure abuse-of-discretion standard that the employer designated and on which MetLife relied when underwriting the Plan's insurance coverage.

B. Respondent's Characterization Of The Insurance Business Is Simplistic And Wrong.

Respondent and the United States contend that the claim determinations of MetLife and other fiduciaries that both evaluate and pay claims should be scrutinized more closely than the plan allows because, in their view, such companies have "a financial stake in every claim for benefits that is submitted under the plan." Resp. Br. 12; *see also* U.S. Br. 16 ("a plan administrator is better off financially when it does not pay benefits"). This simplistic understanding of the insurance business—under which every dollar that a company pays out on a claim comes directly out of the company's "own pocket" and diminishes its profits (Resp. Br. 12)—ignores the sophisticated financial mechanisms that insurance companies use to spread risk and to ensure that they have adequate funds to pay claims while still earning a profit.

This Court has recognized that the "spreading of risk" is "an indispensable characteristic of insurance." *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 212 (1979). Indeed, neither respondent nor the United States disputes that insur-

ance companies utilize a number of financial tools—such as reserves, manual rating, and experience rating—to manage risk and to diminish the financial impact that any one claim for benefits will have upon the company's bottom line. *See, e.g.*, Va. Code Ann. § 38.2-1311 (requiring disability insurers to maintain a reserve calculated based on potential liabilities); Wash. Rev. Code § 48.12.060 (same); *see also* ACLI Br. 13-16.

Respondent instead suggests that, where such mechanisms are in place, the fiduciary should introduce an affidavit outlining these measures and that, under such circumstances, courts may take these factors into account in determining the level of scrutiny to be applied when reviewing a benefit determination of a fiduciary that both evaluates and pays claims. The point, however, is that these economic features are characteristic of the insurance business as a whole, not idiosyncratic details that only appear in unusual cases and that must be affirmatively set forth and pleaded. Moreover, imposing the burden of production on the insurance company is fundamentally inconsistent with the settled rule that the burden of proof in an ERISA action challenging a claim denial rests on the plaintiff. *See, e.g.*, *Gallagher v. Reliance Standard Life Ins. Co.*, 305 F.3d 264, 270 (4th Cir. 2002); *see also* U.S. Br. 26 (acknowledging that burden-shifting would be detrimental).

Respondent's suggestion that this sort of inquiry would impose only minimal burdens on claim administrators and courts also is misguided because the introduction of such an affidavit would merely be used as the occasion for claimants to conduct "big case," full-blown discovery into any business practices described in the affidavit—discovery wholly unrelated to the benefit determination at issue. *See,*

e.g., *Abatie*, 458 F.3d at 969 & n.7 (suggesting that an ERISA claim defendant should produce "affirmative evidence" that it was not operating under a conflict). Such evidentiary inquiries into risk-spreading mechanisms properly rest within the province of state insurance regulators, rather than federal courts. *See* McCarran-Ferguson Act, 15 U.S.C. § 1011. Costly and inefficient discovery into threshold conflict-of-interest issues is also squarely at odds with Congress's intention that ERISA claims litigation proceed in a cost-effective and streamlined manner. *See Varity Corp.*, 516 U.S. at 497. To that end, courts adjudicating ERISA claims generally limit their review to the record developed during the administrative process. *See, e.g.*, *Elliott v. Sara Lee Corp.*, 190 F.3d 601, 608-09 (4th Cir. 1999); *Perry v. Simplicity Eng'g*, 900 F.2d 963, 967 (6th Cir. 1990). The requirement that ERISA claimants, like parties challenging an agency decision, exhaust administrative remedies before filing suit in federal court further indicates the importance of ERISA's goal of minimizing litigation and its costs. *See, e.g.*, *Weldon v. Kraft, Inc.*, 896 F.2d 793, 800 (3d Cir. 1990) ("a federal court will not entertain an ERISA claim unless the plaintiff has exhausted the remedies available under the plan"); *see also* 29 U.S.C. § 1133(2); 29 C.F.R. § 2560.503-1(h).

Respondent and the United States also improperly discount insurance companies' powerful reputational incentive to decide benefit claims in a manner that fairly and faithfully implements the terms of the plan. One need look no further than UnumProvident, which experienced a serious reduction in its market share after it became public that the company had engaged in the systematic denial of meritorious benefit claims, to appreciate the importance of

business reputation to disability benefit insurers. *See* John H. Langbein, *Trust Law as Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials Under ERISA*, 101 Nw. L. Rev. 1315, 1317 n.11 (2007). Because employers offer benefit plans to foster employee loyalty and improve morale, an insurance company that acquires a reputation for denying meritorious claims will inevitably lose business to competitors that have better track records. *See Mers v. Marriott Int'l Group Accidental Death & Dismemberment Plan*, 144 F.3d 1014, 1021 (7th Cir. 1998).

Finally, respondent is unable to distinguish meaningfully between insurance company claim examiners and administrative law judges ("ALJs"), who are not considered to be operating under a conflict of interest even though they decide monetary claims against their employer, the federal government. Respondent emphasizes that ALJs "are public employees bound by a well established set of procedural protections." Resp. Br. 36 (internal quotation marks omitted). ERISA, too, binds claim fiduciaries to act solely in the interest of all plan participants and beneficiaries (29 U.S.C. § 1104(a)(1)), and, in making benefit determinations, they are subject to extensive procedural requirements imposed by the Department of Labor (*see, e.g.*, 29 U.S.C. § 1133(1); 29 C.F.R. § 2560.503-1).

Moreover, respondent and the United States are incorrect when they suggest that the abuse-of-discretion standard that *Firestone* specified for discretionary benefit determinations is qualitatively different from the standard applied under the Administrative Procedure Act ("APA") to agency decisions. Resp. Br. 43; U.S. Br. 29 n.3. Courts have long recognized that whether the standard of review for dis-

cretionary benefit determinations is given the "abuse of discretion" or "arbitrary and capricious" label, it is analogous to review of agency decision-making under the APA. Indeed, relying on then-Judge Ginsburg's opinion in *Block v. Pitney Bowes Inc.*, 952 F.2d 1450, 1454 (D.C. Cir. 1992), the United States itself has previously acknowledged as much. *See* Br. for the United States as Amicus Curiae at 13-14, *Nord* (No. 02-469).

Thus, just as ALJs are not presumed to be biased in favor of their employer simply because the federal government has a financial interest in the claims they decide, ERISA claim administrators should not be deemed to operate under a conflict of interest unless there is evidence in the administrative record that their decision-making was infected by concerns about their employer's financial interests.[6]

C. Respondent Improperly Discounts The Regulatory Safeguards That Protect Plan Participants From Biased Decision-Making.

Respondent suggests that oversight of insurance companies that serve as plan fiduciaries by the De-

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[6] The United States also attempts to distinguish claim examiners and ALJs on the ground that "the federal government itself, unlike an insurance company, is not a for-profit institution." U.S. Br. 21. The United States is wrong to suggest that all insurance companies are for-profit entities. *See, e.g., Lee v. Blue Cross/Blue Shield of Ala.*, 10 F.3d 1547, 1552 n.6 (1994) (noting Blue Cross' status as a not-for-profit entity). But even where a claims examiner is employed by a for-profit enterprise, the theoretical incentive to maximize his employer's profits is no different than a government employee's incentive to please his superiors by saving the federal government money and preserving the limited budget of the agency by which he is employed.

partment of Labor and state insurance departments "is no substitute" for courts' consideration of individual benefit determinations. Resp. Br. 39. But the fact that state and federal regulatory oversight, on the one hand, and judicial review under ERISA, on the other, may serve complementary functions does not mean that courts are free to alter the standard of review that the employer intends by delegating discretionary authority to its funding source under the terms of its plan. Much less does it establish that federal courts should become *ad hoc* insurance regulators by conducting detailed evidentiary reviews of actuarial assumptions, risk spreading, and other similar factors that are wholly unrelated to the benefit determination. It instead establishes simply that plan participants should be given the opportunity to seek court-ordered relief from unreasonable claim denials. ERISA and the plan documents here guarantee plan participants that right, as well as the opportunity to seek full and fair review of benefit determinations through insurance companies' internal administrative review processes. *See* AHIP Br. 13.

The aberrant example of UnumProvident, which respondent invokes (at 17) in an effort to demonstrate the necessity for heightened scrutiny, merely reinforces the fact that state regulators will inevitably uncover—and remediate—any systematic wrongdoing by insurance companies. Judicial review under the traditional abuse-of-discretion standard—in combination with administrative review through an insurance company's internal procedures and with federal and state regulatory oversight—is thus sufficient to uncover similar episodes. Indeed, although the National Association of Insurance Commissioners suggests otherwise, it is passing strange for regulators to disavow their ability to uncover potential

abuse by holding up an example of an abuse that was actually uncovered by their efforts. *See* NAIC Br. 13.

II. If MetLife Is Deemed To Be Operating Under A Conflict Of Interest That Must Be Weighed On Judicial Review, The Conflict Should Be Only One Factor Considered In Determining Whether MetLife Abused Its Discretion.

Firestone establishes that, if an entity that both evaluates and pays claims is operating under a conflict of interest that must be weighed on judicial review, that conflict should be weighed as only one factor in determining whether the entity abused its discretion in denying or terminating benefits. Echoing the Ninth Circuit's decision in *Abatie*, however, respondent and the United States disregard this Court's guidance in *Firestone* and instead propose a nonexclusive list of seven factors to be used in determining the degree of deference afforded to the decisions of a conflicted fiduciary. Respondent's proposed standard is legally flawed and also suffers from serious practical shortcomings. Not the least of these shortcomings is respondent's newly minted contention that this case should be resolved under *de novo* review. *Compare* Resp. Br. 49, *with* Br. in Opp. 24 (endorsing heightened abuse-of-discretion review).[7] If this case is an appropriate candidate for *de novo* review, it is difficult to conceive of any case in-

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[7] Before the court of appeals, respondent observed that MetLife both evaluated and paid benefit claims, but never asserted that it was actually operating under an improper motive. *See* Resp.'s C.A. Opening Br. 22.

volving at least some conflicting medical evidence where *de novo* review would not be appropriate.

A. Respondent's Proposed Standard Of Review Is Inconsistent With This Court's Precedent And With ERISA's Statutory Objectives.

In *Firestone*, this Court made clear that, where a "fiduciary . . . is operating under a conflict of interest," that conflict is to be "weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" 489 U.S. at 115 (quoting Restatement (Second) of Trusts § 187 cmt. d) (alteration in original). Respondent acknowledges the standard articulated in *Firestone*, but then proposes that courts apply it in a manner that is more akin to *de novo* review than to the traditional arbitrary-and-capricious standard specified in *Firestone*. Specifically, respondent suggests that courts "re-weigh the evidence" before the fiduciary and require "complete and careful explanations," while "cast[ing] a skeptical eye on the explanations they do receive" and "exhibit[ing] little tolerance for analytical flaws or evidentiary gaps." Resp. Br. 44.

Respondent's proposed modification to the abuse-of-discretion standard is directly at odds with this Court's holding in *Black & Decker Disability Plan v. Nord*, 538 U.S. 822 (2003), that ERISA does not "impose on plan administrators a discrete burden of explanation" in writing when they "credit reliable evidence that conflicts" with evidence presented by the claimant. *Id.* at 834. Respondent's contention that fiduciaries that are operating under a conflict of interest should be required to "provide complete and careful" explanations of every aspect of their decision cannot be reconciled with this aspect of *Nord*.

Moreover, the suggestion of respondent and the United States that courts should "diminish[ ] deference" to a fiduciary's decision based on a panoply of factors—ranging from "reversal of position without additional medical evidence" to "denying disability after advocating disability to the SSA" (Resp. Br. 49; U.S. Br. 27)—is both practically flawed and legally erroneous. From a practical standpoint, encouraging courts to consider an ill-defined range of factors extrinsic to the administrative record would inevitably invite costly and time-consuming discovery in a number of otherwise routine benefit cases, in direct contravention of Congress's "desire" in enacting ERISA "not to create a system that is so complex that . . . litigation expenses[ ] unduly discourage employers from offering welfare benefit plans." *Varity Corp.*, 516 U.S. at 497. The prospect of potentially onerous discovery in virtually every run-of-the-mill benefit case is likely to discourage employers from establishing benefit plans in the first instance and to compel insurance companies to increase premiums for existing plans—thereby exacerbating financial burdens on employers and/or participants, and likely prompting a reduction in the generosity of plan benefits. *See Newman v. Standard Ins. Co.*, 997 F. Supp. 1276, 1280-81 (C.D. Cal. 1998) (noting the "immense practical problems associated with" discovery into whether a fiduciary was operating under a conflict of interest, which could result in the "expense of ERISA litigation . . . easily be[ing] more than the benefits at issue").

Moreover, such multi-factored tests are invariably difficult "to apply, jettisoning relative predictability for the open-ended rough-and-tumble of factors." *Jerome B. Grubart, Inc. v. Great Lakes Dredge & Dock Co.*, 513 U.S. 527, 547 (1995). Indeed, the

Court has experimented with multi-pronged standards in the past (*see, e.g.*, *Relford v. Commandant*, 401 U.S. 355, 365 (1971) (12-factor test)), only to abandon them as unworkable in later cases due to the "confusion" they inevitably generate (*Solorio v. United States*, 483 U.S. 435, 449 (1987)). This is a particular concern here, where the determinations are highly fact-sensitive and individualized. Adopting respondent's malleable slate of subjective factors would deprive the lower courts of meaningful guidance and inevitably generate uncertainty for plan sponsors, fiduciaries, and participants.[8]

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[8] Moreover, the application of those factors to the facts of this case would not warrant a reduction in the deference due MetLife's benefit determination, nor does respondent explain how they could. First, MetLife did not "revers[e] [its] position without additional medical evidence." Resp. Br. 49. The Plan's definition of disability became more restrictive after two years. This Plan change required the termination where undisputed medical evidence showed that respondent's cardiac condition had stabilized. J.A. 23a, 25a. Nor did MetLife "'self-servingl[y]'" disregard Dr. Patel's reports that supported respondent's position. MetLife noted Dr. Patel's post-denial opinions that respondent was disabled from sedentary work, but concluded that they were outweighed by contrary medical evidence and physicians' opinions. *Id.* at 25a-26a. Furthermore, MetLife did not provide inconsistent reasons for its termination of respondent's benefits. It instead consistently explained that the medical evidence did not support a finding that respondent was disabled from performing any occupation. *Id.* And MetLife did not terminate respondent's benefits without an investigation into its merits. It conducted a thorough inquiry into her claim, obtaining the opinions of an in-house nurse consultant and two independent physicians, as well as a transferable skills analysis. Nor did MetLife "'fail[ ] to credit'" respondent's "reliable evidence"; rather, it reasonably concluded that her physician's post-denial opinions were unreliable and were outweighed by other, more reliable evidence that she was capable

B. Respondent's Reading Of The Administrative Record Is Flawed.

Whatever the appropriate standard of review in this case—the *de novo* standard urged by respondent, the watered-down abuse-of-discretion standard endorsed by the United States, or the fully deferential abuse-of-discretion standard advocated by MetLife—respondent and the United States are wrong to suggest that MetLife improperly terminated respondent's long-term disability benefits or that its decision-making process was flawed.

Contrary to respondent's assertion, MetLife's termination of Glenn's benefits was premised on much more than Dr. Patel's supposedly "aberrational X." Resp. Br. 5. As an initial matter, Dr. Patel's statement that respondent was "able to work in a sedentary physical exertion level occupation" was hardly aberrational or careless. J.A. 58a. In the same document, Dr. Patel responded "N/A" when asked to "explain current physical barriers preventing Ms. Glenn from returning to fulltime" (*id.*)—a clear indication that Dr. Patel understood that, when checking "yes" to the earlier question, he was communicating to MetLife that respondent was capable of performing full-time sedentary work. This opinion was consistent with Dr. Patel's conclusions in both January and June 2002, with the opinions of three other independent physicians (Pet. App. 45a; J.A. 37a, 54a-56a, 59a-61a; C.A. App. 170), and with the fact that, when

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[Footnote continued from previous page]

of sedentary work. *Id.* at 25a-26a. Finally, MetLife did not "'advocat[e]'" disability to the SSA. MetLife neither appeared in those proceedings nor directed respondent's lawyers on the exercise of their professional judgment.

her benefits were terminated, respondent's heart function had significantly improved from the time that she first started receiving disability benefits. J.A. 74a.

Respondent's contention that MetLife should have disregarded Dr. Patel's pre-denial opinions, the conclusions of these three other independent physicians, and the medical evidence contradicting the opinion that Dr. Patel expressed during the administrative review process effectively seeks to overturn this Court's conclusion in *Nord* that claim administrators are not "require[d]" to "accord special weight to the opinions of a claimant's physician." 538 U.S. at 834.[9] Deference to the treating physician would be especially inappropriate in this case, where each of Dr. Patel's post-denial letters contained material statements that are impeached by objective evidence, some from his own records. *Compare* J.A. 44a ("patient has tried to return to work"), *with id.* 19a, ¶ 2 ("Per C[ase]M[anager]S[pecialist,] E[mploye]R interview 8/9/02 there was no prior R[eturn]T[o]W[ork] since disability" began); *compare id.* 42a (the implanted cardiac "device has no roll [sic] in terms of improving her cardiac function"), *with id.* 75a (new biventricular pacing device implanted).

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[9] This case does not even present the classic scenario of treating physician opinion versus insurance company medical director opinion because MetLife never inquired of any staff physician, and relied heavily on the reliable information supplied by the treating physician himself. J.A. 59a-60a, 57a-58a, 54a. The determination of which of the treating physician's opinions to credit—pre- or post-denial of benefits—was based on the objective medical testing in the treating physician's own files (*id.* at 46a; C.A. App. 228), and the opinions of three independent physician consultants, one of whom was not even hired by the Plan for an opinion. Pet. App. 45a; J.A. 37a; C.A. App. 170.

None of the other purported flaws in MetLife's reasoning identified by the court of appeals and respondent warrants reinstatement of respondent's disability benefits. For example, under *Nord*, MetLife was not required to provide a written explanation for its decision not to defer to the findings of the SSA proceedings. 538 U.S. at 834. Moreover, because *Nord* held that a claim administrator—unlike the SSA (20 C.F.R. § 404.1527(d)(2))—is not required to give special weight to a treating physician's opinion, respondent's argument that MetLife was required to refute the SSA determination gives a treating physician's opinion a degree of weight that this Court explicitly rejected in *Nord*. The result of the SSA proceeding is inapposite, in any event, because respondent bore the burden of proving to MetLife that she was totally disabled, whereas the government bore the burden of establishing that respondent was capable of returning to full-time work in the SSA proceeding.[10]

Respondent is also wrong when she suggests that MetLife itself argued to the SSA that she was entitled to government benefits. In accordance with its standard practice under plans that offset estimated and actual social security benefits, MetLife recommended a law firm specializing in social security claims, which respondent selected to represent her in the SSA proceeding. MetLife did not participate in

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[10] Respondent faults MetLife for addressing the court of appeals' misplaced reliance on the SSA determination in its opening brief. Resp. Br. 52. As the United States itself recognized, however, "any application of the correct legal standard to this case[] may involve discussion of the treatment of the SSA award as part of the reasonableness analysis." U.S. Cert. Br. 21.

that proceeding and never argued to the SSA that respondent was disabled. Moreover, recommendation of counsel was consistent with MetLife's fiduciary obligation to the plan to ensure that beneficiaries with alternative sources of disability payments receive those awards and reimburse the Plan for overpayments.[11]

Similarly, respondent faults MetLife for failing to provide a "'reason for rejecting'" Dr. Patel's post-denial, inconsistent opinion that respondent was disabled from sedentary work (Resp. Br. 54-55 (quoting Pet. App. 19a)) and for "'offer[ing] no explanation for its resolution of the conflict'" between Dr. Patel's divergent views of respondent's ability to return to work. *Id.* at 55 (quoting Pet. App. 20a) (emphasis omitted). But respondent again disregards *Nord*'s holding that ERISA does not "impose on plan administrators a discrete burden of explanation." 538 U.S. at 834. Moreover, although MetLife was under no obligation to explain its reasons for concluding that Dr. Patel's conveniently-timed reassessment of respondent's medical condition was not credible, it in fact did so, in exactly the manner that the United States recently endorsed. *See* Br. for the United States as Amicus Curiae at 15, *Nord* (No. 02-469) ("the reasons that an administrator did not rely on the treating physician's opinion may reasonably be

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[11] MetLife's recommendation was also consistent with respondent's best interests because, for example, the Plan does not offset social security cost-of-living adjustments. J.A. 169a; *see also id.* at 145a-46a (October 10, 2000, letter explaining other advantages to respondent). The United States also mistakenly contends that "MetLife directed respondent to apply for Social Security disability benefits." U.S. Br. 4. As respondent herself acknowledges, however, she applied for SSA benefits without any prompting from MetLife. Resp. Br. 4 n.2.

apparent from other medical evidence, . . . tests, or examinations, as well as non-medical evidence, that rebut the opinion of the treating physician regarding the claimant's condition or limitations"); *see also* J.A. 31a-32a (explaining that there were no post-disability medical records of decompensation from stress and that several types of full-time sedentary work fit respondent's medical criteria and were, on their face, low stress); *id.* at 25a (explaining the role of respondent's biventricular pacemaker in improving her condition, and other objective medical test results). Under both ERISA and the plan documents, the resolution of this factual issue rested in the sound discretion of MetLife, was reasonable, and may not be second-guessed by a court.

CONCLUSION

For the foregoing reasons, the judgment of the court of appeals should be reversed.

Respectfully submitted.

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